STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005035	A. BUILDING _____ B. WING _____	05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK REGIONAL HOSPITAL	801 N STATE ST GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint: IN00102100 Unsubstantiated, lack of sufficient evidence. Date of Survey: 05-17-12 Facility number: 005035 Surveyors: John Lee, R.N. Public Health Nurse Surveyor Hancock Regional Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules. QA: claughlin 06/18/12	S 000		